

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

02824

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH: Harford  
 County.....  
 City or town..... Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 years.  
 Hospital, institution, or street address where death occurred:  
Osborne Avenue, Aberdeen, Md.  
 How long in hospital or institution? home.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Harford  
 City or town..... Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Osborne Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... none

3. (a) FULL NAME  
Mary Ann Dolan Baswell

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Lonnie A. Baswell

7. Birth date of deceased (mo., day, yr.) January 30, 1905 6. (c) If alive, give age..... years

8. AGE: Years 43 Months 1 Days 49 If less than one day 9 hrs. 20 min.

9. Birthplace..... Baltimore City, Md.  
 (Town, county, and state)

10. Usual occupation..... housewife.

11. Industry or business..... none

12. Name..... John Francis Dolan

13. Birthplace..... Baltimore, Maryland

14. Maiden name..... Mary Margaret Roth

15. Birthplace..... Baltimore City, Md.

16. Informant..... Mary Roth Price

Address..... Aberdeen, Md.

17. burial. Date thereof..... Mar. 22-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Sacred Heart of Jesus

Location..... Baltimore Md.

18. Funeral director..... Henry James Sons

Address..... Aberdeen Md.

19. Mar 20 19 48 Nellie H. Coker  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 19 1948 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1948 to March 19 1948

and that I last saw her alive on March 13 1948

Immediate cause of death..... hypostatic pneumonia DURATION 5 days

Due to..... paraplegia of legs 12 years

Due to..... spine injury 1936 12 years

Other conditions..... idiopathic 30 years

epilepsy (Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op..... none.

Autopsy results..... none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

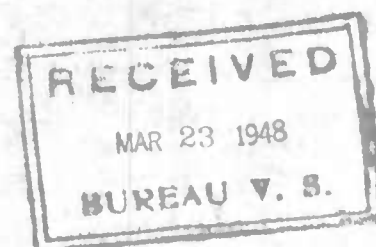
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Arthur V. Gould Jr. M.D.

Address..... Haute de Grace, Md. M. D. or other 3/19/48  
 Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

1646 02825

182

## 1. PLACE OF DEATH:

County Harford  
City or town Whiteford Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
City or town Whiteford Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

CLARENCE MC BENNINGTON

## 3. (b) Social Security Number

217-05-2195

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) October 28, 1901

## 8. AGE:

46 Years4 Months16 Days

If less than one day

..... hrs. .... min.

## 9. Birthplace

Whiteford, Md.  
(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Horatio S. Bennington

## 13. Birthplace

Whiteford, Md.

## 14. Maiden name

Anne M. McCleary

## 15. Birthplace

York Co. Pa.

## 16. Informant

Ralph L. Bennington

## Address

Red Lion, Pa.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Mar. 20 - 1948  
(month) (day) (year)

## Cemetery or crematory

Slaterville cemetery

## Location

Delta, Pa.

## 18. Funeral director

Hubert P. Barker

## Address

Delta, Pa.

## 19.

(Date rec'd by registrar)

March 17, 48 M. V. Kinde

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 14 1948 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him..... alive on ..... 19.....

Immediate cause of death

DROWNING - SUICIDAL

## DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide SUICIDE Date of 3/14/48Where did injury occur? near CARDIFF HARFORD MD.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) PROCTORS QUARRYMeans of injury Jumped in Quarry Injured at work? No

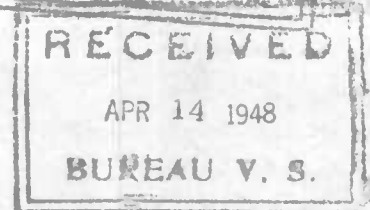
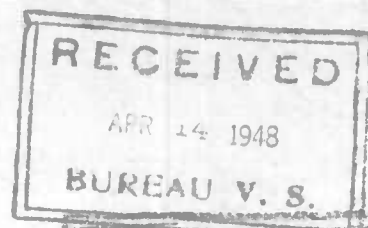
23. SIGNATURE

J. P. Ramsey, M.D.  
Address Aberdeen, Md. Date signed 3/17/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02826

## CERTIFICATE OF DEATH

Reg. Dist. No. 781

1. PLACE OF DEATH: Harford  
County Rural - Aberdeen  
City or town 70 yrs.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Harford  
City or town Chesapeake  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Churchville  
(If rural, give LOCATION)  
2(a) If veteran, name war None

3. (a) FULL NAME Eugene Billingslea

3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed or divorced Married  
6. (b) Name of husband or wife Emma C. Rodt  
6. (c) If alive, give age 66 years  
7. Birth date of deceased (mo., day, yr.) November 7th 1877  
8. AGE: Years 70 Months 4 Days hrs. min.

9. Birthplace Calvary, Harford Co., Md.  
(Town, county, and state)

10. Usual occupation Pen. Canteen, Rtd.

11. Industry or business

12. Name Charlie W. Billingslea

13. Birthplace Calvary, Harford Co., Md.

14. Maiden name Virginia Mc. Donnell

15. Birthplace Churchville, Harford Co., Md.

16. Informant Mrs. Eugene Billingslea

Address Aberdeen, Md. P.O. D.

17. Burial (Burial, cremation, or removal, Which?) Male 14 1948

Cemetery or crematory Smith's Chapel

Location Churchville, Md.

18. Funeral director Henry Tarrington & Sons

Address Aberdeen, Md.

19. Mar. 13 48 Nellie R. Wiley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH March 11th 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1976 to Mar 11 1978  
and that I last saw him alive on Mar 11 1978

Immediate cause of death Carcinoma of Rectum

Due to Carcinoma of Rectum

Due to

Other conditions Cachexia

(Include pregnancy within 3 months of death)

Major findings of operations as above

Date of op. 8/1945  
11/1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley, M.D.

M.D. or other

Address Harford Co. Md. Date signed 3/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

**MAR 16 1948**

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

02827

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County.....Harford  
 City or town.....Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....1 hour  
 Hospital, institution, or street address where death occurred.....17 Liberty St.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....New York County.....  
 City or town.....Buffalo  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....1113 W. Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Louis SALVATORE BONGIOVANNI

## 3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married  
 6.(b) Name of husband or wife.....Valerius Scaroni  
 7. Birth date of deceased (mo., day, yr.).....April 21st 1882 6.(c) If alive, give age.....57 years  
 8. AGE: Years.....65 Months.....11 Days..... If less than one day..... hrs. .... min.

9. Birthplace.....Italy  
 (Town, county, and state)  
 10. Usual occupation.....Contractor  
 11. Industry or business.....  
 12. Name.....Nicholas Bongiovanni  
 13. Birthplace.....Italy  
 14. Maiden name.....Unknown  
 15. Birthplace.....Italy

16. Informant.....N. J. Bonge  
 Address.....# 7 Liberty St. Aberdeen, Md  
 17. Removal.....Removal Date thereof.....Mar 30, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....St. Calvert  
 Location.....Buffalo, N. Y.  
 18. Funeral director.....Henry Tarkenton & Sons  
 Address.....Aberdeen, Md

19. Mar 30 19 48 Nellie H. Riley  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 29 19 48 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19..... to.....19.....  
 and that I last saw h.....alive on.....19.....

Immediate cause of death.....Coronary Occlusion  
 DURATION.....

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE.....J. Ramsey, M.D.  
 Address.....Aberdeen, Md Date signed.....3/29/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 1 1948

BUREAU V. S.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

02828

Reg. Diat. No. 185

## 1. PLACE OF DEATH:

County Hartford  
 City or town HAVERDE GRACE  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 yrs.  
 Hospital, institution, or street address where death occurred:  
Hartford Memorial Hospital  
 Now long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Hartford  
 City or town Haverde Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 428 S. Washington St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mr. Norval Carr

## 3. (b) Social Security Number

## 4. Sex

M.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

(Circled)

## 6. (b) Name of husband or wife

Agnes C. Carr

## 7. Birth date of deceased (mo., day, yr.)

May 2, 1891

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

5-6106

hrs.

min.

## 9. Birthplace

Hartford Co.

(Town, county, and state)

## 10. Usual occupation

Carpenter

## 11. Industry or business

MOTHER FATHER

## 12. Name

Ortha Carr

## 13. Birthplace

Hartford Co.

## 14. Maiden name

Shank?

## 15. Birthplace

?

## 16. Informant

Agnes C. Carr(Wife)

## Address

428 S. Washington St.

## 17.

Burial

## Date thereof

3/11/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Angel Hill

## Location

Haverde Grace

## 18. Funeral director

Pennington & Son

## Address

Haverde Grace

## 19.

Mar. 10, 1948

(Date rec'd by registrar)

G. L. Lewis M. D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th 1948 at 4:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 8, 48 19, to same 19.and that I last saw him alive on same 19.

## Immediate cause of death

acute coronary occlusion

## DURATION

Due to

Due to

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Nogueira M.D.

M. D. or other

Address

Haverde GraceDate signed 3.8.48

RECEIVED

MAR 12 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

02829

Reg. Dist. No. 183

### 1. PLACE OF DEATH:

County Harford

City or town Street  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford

City or town Street  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Caroline Williamson Collier

### 3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife Frank A. Collier

7. Birth date of deceased (mo., day, yr.) Dec 12, 1898

6. (c) If alive, give age years

8. AGE: Years 69 Months 3 Days 1 It less than one day  
hrs. min.

9. Birthplace Philadelphia, Pa.  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Charles H. Heite

13. Birthplace Philadelphia, Pa.

14. Maiden name Eleanor Williamson

15. Birthplace Philadelphia, Pa.

16. Informant Mrs. David Heite

Address Street Md.

17. Burial Date thereof Mar 17, 1948  
(Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory Mount Rose

Location Highland Park, Pa.

18. Funeral director Warren Roberts

Address Penetanguetsee Ind.

19. Mar. 16 19 48 Thomas R. Brown  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 19 48, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47 to March 12, 19 48

and that I last saw him alive on March 12, 19 48

Immediate cause of death Cerebral Hemorrhage

DURATION

1 wks.

Due to Hypertensive cardio vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles E. Jeff MD.

Address Street, Ind. Date signed 13-12-48

MARGIN RESERVED FOR BINDING

I

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 18 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02830

## CERTIFICATE OF DEATH

Reg. Dist. No.

185

## 1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Perryville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

Baby Girl Du Free (Dora Elaine)

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

C.

## 6. (a) Single, married, widowed, or divorced

newborn infant

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 29 - 488. AGE: Years Months Days It less than one day  
0 0 4 hrs. min.9. Birthplace Harre de Grace - Harford - Md  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name Joseph Du Free13. Birthplace Maryland14. Maiden name Jessie Patterson15. Birthplace Ga.16. Informant Joseph Du FreeAddress Perryville, Md.17. Burial Date thereof Mar 5 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CokesburyLocation Port Deposit, Md. R.D.18. Funeral director Lee A. Patterson's SonAddress Perryville, Md.19. Mar 5 1948 Registrar G. L. Lewis M.D.  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4<sup>th</sup> 48 at 3<sup>55</sup> P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Central respiratory failure  
Prematurity

Due to

Due to

Other conditions

Hemolytic disease of the newborn  
(mother had hydramnios)  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Voguera MD.Address Hospital - Harre de Grace Date signed 3.4.48

RECEIVED

MAR 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02831

Reg. Dist. No. 180

## 1. PLACE OF DEATH:

County HARFORDCity or town EDGEWOOD  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 1/2 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Edgewood  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

MARY ANN EDWARDS

## 3.(b) Social Security Number

4. Sex Female5. Color or race white6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Thomas R Edwards

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb 12, 18698. AGE: Years 79 Months 1 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Mahanoy City Pa  
(Town, county, and state)10. Usual occupation housewife

## 11. Industry or business

12. Name Stewellyn Biddow13. Birthplace Wales14. Maiden name Ann Jenkins15. Birthplace Wales16. Informant Mrs Ralph LohrAddress 29 Arundel St, Edgewood Md  
17. Transportation Date thereof Mar 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Funeral Home  
Mahanoy City Penna  
Location \_\_\_\_\_18. Funeral director Howard K. McConnon  
Address Abingdon Maryland19. Mar 17 19 48 Mary M Mondsdales  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 19 48 at 1:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/13 19 48 to 3/15 19 48and that I last saw h. ER alive on 3/13 19 48Immediate cause of death PROBABLE CORONARY DURATION 2 DAYS  
OCCLUSIONDue to ARTERIOSCLEROSIS

Due to \_\_\_\_\_

Other conditions NONE EXCEPT DIFFUSE  
MYOCARDIAL DAMAGE  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results NOT DONE  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following: \_\_\_\_\_  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE C. W. Stewart Jr, M. D. M. D. or otherAddress 12 YAHDE ST. EDGEWOOD MD Date signed 3/15/48

**RECEIVED**

MAR 19 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02832

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County Harford  
 City or town Aberdeen Proving Ground, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 48 days  
 Hospital, institution, or street address where death occurred:  
Bks 158 Ord Sch Aberdeen Proving Ground, Md.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Pennsylvania County Huntingdon  
 City or town Alexander  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. General Delivery  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War II

## 3. (a) FULL NAME

EMES, GEORGE F.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife  
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 18, 1918

8. AGE: Years 30 Months 0 Days 16 If less than one day  
 hrs. min.

9. Birthplace Johnstown, Pennsylvania  
 (Town, county, and state)

10. Usual occupation Soldier

11. Industry or business U. S. Army

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Personnel Section Ordnance School

Address Aberdeen Proving Ground, Maryland

17. Transportation Date thereof Mar 4, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Temple Funeral Home

Location Petersburg, Virginia

18. Funeral director Howard K. McCombs

Address Chungdon Maryland

19. Mar 8 19 48 Mellie F. Riley  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 19 48 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19 to 19  
 and that I last saw him alive on Dead on arrival 19

Immediate cause of death unknown DURATION

(pending analysis of laboratory)

Due to From available evidence, a definite cause of death cannot be established  
 Due to [4/27/48 obs]

Other conditions Atelectasis, bilateral  
partial  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George F. Emes or other

Address Aberdeen Proving Ground, Md. Date signed Mar 3, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

Huntingdon

RECEIVED

MAR 9 1948

BUREAU V. S.

Evidence for change of age  
and birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1750

02833

FILE No. G 114 MAR 30 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford  
City or town Forest Hill (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 days  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md. County Harford  
City or town Forest Hill (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Martha Tannier Epper

3. (b) Social Security Number

4. Sex Female 5. Color or race col 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Joshua Epper

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) May 9 1908 1910

8. AGE: Years 37 Months 10 Days 4 If less than one day hrs. min.

9. Birthplace Michigan Va  
(Town, county, and state)

10. Usual occupation house wife

11. Industry or business

12. Name Charles Booker

13. Birthplace Va

14. Maiden name Mary W Eggleston

15. Birthplace Va

16. Informant Joshua Epper

Address Forest Hill md

17. Burial Date thereof March 17-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Keepsville

Location Va

18. Funeral director Katie R Williams

Address 322 N. Schroeder St Baltimore

19. Mar 16 19 48 Thomas R Brown  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 48 at 11:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
to to  
and that I last saw him alive on to

Immediate cause of death Fracture cervical vertebra  
Due to

Due to Tractor accident

Other conditions Fracture skull compound & comminuted  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Accident Date of 3/13/48  
Where did injury occur? Forest Hill Harford md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Farm  
Means of injury Tractor upset Injured at work? yes

Ronald C Palmer MD  
23. SIGNATURE Henry Roberts Medical Examiner  
Harford County M. D. or other  
Address Bel Air md Date signed

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 18 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02834

Reg. Dist. No. 180

## 1. PLACE OF DEATH:

County HarfordCity or town Edgewood  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Edgewood  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ida May Gaunt

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Charles B. Gaunt

## 7. Birth date of

deceased (mo., day, yr.)

Nov. 17, 1869

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

7842

hrs.

min.

## 9. Birthplace

Edgewood, Harford Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

## (Burial, cremation, or removal. Which?)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date rec'd by registrar

## 20. Date of death

## 21. Signature

## Address

## 22. Date signed

## 23. Date of death

## 24. Date of death

## 25. Date of death

## 26. Date of death

## 27. Date of death

## 28. Date of death

## 29. Date of death

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 19, 1948 at 12:58 PM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1945 to March 1948  
and that I last saw alive on March 18, 1948

## Immediate cause of death

## DURATION

## Due to

## Due to

## Other conditions

## Major findings of operations

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

## Injured at work?

## 23. SIGNATURE

Dr. Ralph H. H. H.  
Chesapeake, Md. Date signed March 19

RECEIVED

MAR 24 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

02835

Reg. Dist. No. 185-

### 1. PLACE OF DEATH:

County Harford  
City or town Haine de Grace  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
How long in hospital or institution? 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford  
City or town Haine de Grace  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 125 S. Washington St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Miss Rose Green

### 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) ☒ Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 2 - 1863 6. (c) If alive, give age years

8. AGE: Years 84 Months 6 Days 22 If less than one day  
hrs. min.

9. Birthplace Haine de Grace  
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Lytleton Green

13. Birthplace Haine de Grace

14. Maiden name Paula E. Powell

15. Birthplace Haine de Grace

16. Informant Robert Pennington

Address Haine de Grace

17. Cremation Date thereof 4/1/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Greenmont

Location Baltimore, Md.

18. Funeral director Pennington & Son

Address Haine de Grace, Md.

19. Mar. 30 19 48 G. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 29<sup>th</sup> 48 19 48 11 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25<sup>th</sup> 48 to March 29<sup>th</sup> 48  
and that I last saw her alive on March 29<sup>th</sup> 48

Immediate cause of death Hypertensive cardiovascular disease

Due to congestive heart failure and

Due to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Noguera MD

Address Hospital - Haine de Grace Date signed 3. 29. 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 1 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02836

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County HarfordCity or town Garrettsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Garrettsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Jane Hall

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

Col

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife

Joshua Hall

7. Birth date of deceased (mo., day, yr.)

Jan. 3, 1851

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

97127

hrs.

min.

9. Birthplace

Garrettsville

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER  
MOTHER

12. Name

Lairson Francis

13. Birthplace

Not known

14. Maiden name

Charity

15. Birthplace

Not known

16. Informant

Stanley Gover

Address

Forest Hill, Md

17.

(Burial, cremation, or removal) Which?

Date thereof

Mar. 4, 1948  
(month) (day) (year)

Cemetery or crematory

Fairview

Location

Forest Hill, Md

18. Funeral director

Martin G. Kury

Address

Garrettsville, Md.

19.

Mar. 4  
(Date rec'd by registrar)1948Thomas R. Brown

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 2, 1948, at 1:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 241948to Mar 21948and that I last saw her alive on Mar 1 1948

Immediate cause of death

Chr Cardio-Vascular Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson M.D

M. D. or other

Address

Forest Hill, MdDate signed 3/3/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
464  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

02837

Reg. Dist. No. 186-

## 1. PLACE OF DEATH:

County Harford  
City or town Laure de Grace  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days in Hosp.  
Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
City or town Fallston  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Harry J. Hess

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) May 15 - 1874  
8. AGE: Years 71 Months 10 Days 5 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rutledge Maryland  
(Town, county, and state)  
10. Usual occupation Storekeeper  
11. Industry or business Graces Sen Indis.  
12. Name Harold H. Hess  
13. Birthplace Harford co Md.  
14. Maiden name Mary Preston  
15. Birthplace Harford co Md

16. Informant Milton Hess  
Address Fallston Md  
17. Burial Date thereof March 22-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Good Will  
Location Rutledge Harford co Md  
18. Funeral director Martin E. Rust  
Address Carettsville Md.  
19. Mar. 21 19 48 A. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-48 19. \_\_\_\_\_ at 5:25 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-17-48 to 3-20-48  
and that I last saw him alive on 3/20  
Immediate cause of death Cardiovascular  
Due to Exhaustion - Anemia  
Due to Probably Cancer of  
Other conditions liver

## DURATION

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work \_\_\_\_\_

23. SIGNATURE Harold Hess M.D. or other \_\_\_\_\_  
Address Fallston Md Date signed 3-24-48

RECEIVED

MAR 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02838

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

## 1. PLACE OF DEATH:

County Harford  
City or town Rural - Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? About

Hospital, institution, or street address where death occurred:

West Belair Ave., extended

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Rural - Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)Street No. Belair Ave., extended  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jennie W. Holloway

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

William E. Holloway

7. Birth date of

deceased (mo., day, yr.)

June 19, 1871

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76105

hrs.

min.

9. Birthplace

Franklinville, Balto. Co., Md.  
(Town, county, and state)

10. Usual occupation

At home

11. Industry or business

12. Name John A. Burrier

13. Birthplace

Unknown

14. Maiden name

Sarah W. White

15. Birthplace

Cecil Co., Md.

16. Informant

Miss Reils Foster

Address

Aberdeen, Md. R.F.D.

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

March 27, 1948  
(month) (day) (year)

Cemetery or crematory

Grove Presbyterian

Location

Aberdeen, Md.

18. Funeral director

Perry Taxing & Son

Address

Aberdeen, Md.

19.

(Date rec'd by registrar)

Mar 25 48Nellie F. Riley

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1948, at 3:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 19, 48 to March 24, 1948and that I last saw her alive on March 24, 1948

Immediate cause of death

Respiratory failureDue to Transition - DehydrationDue to Thrombosis of middle cerebral artery, with infarctionOther conditions Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Nellie F. Riley M.D. or otherAddress Aberdeen, Md. Date signed 3/25/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02839

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County Harford  
 City or town Harre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? \_\_\_\_\_  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
 How long in hospital or institution? 5 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Harford  
 City or town Harre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 618 Fountain St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mr. Malcolm Hummel Jr

## 3. (b) Social Security Number

166-03-0300

## 4. Sex

M.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ruth Hagg Hummel

## 7. Birth date of deceased (mo., day, yr.)

6-18-17

## 8. (c) If alive, give age \_\_\_\_\_ years

30

## 8. AGE:

Years

Months

Days

If less than one day

30910

hrs.

min.

## 9. Birthplace

Penn  
(Town, county, and state)

## 10. Usual occupation

Cashier

## 11. Industry or business

First Natl. Bank

## MOTHER

## 12. Name

Malcolm C. Hummel Sr

## 13. Birthplace

Penn.

## 14. Maiden name

Helen Treener

## 15. Birthplace

Penn.

## 16. Informant

Mrs Ruth Hagg Hummel

## Address

618 Fountain St.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Apr 1st 1948  
(month) (day) (year)

## Cemetery or crematory

Union Cem.

## Location

Stodington, Penn.

## 18. Funeral director

R. Madison Mitchell

## Address

Harre de Grace, Md.

## 19.

(Date rec'd by registrar)

Mar. 30 19 48G. L. Lewis M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 48 at 2:05 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28-48 to same 19.and that I last saw him alive on same 19.

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

7

## Due to

## Due to

## Other conditions

Tuberculosis of Kidney and bladder - Secondary anemia  
(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

John F. Noguera MD  
M.D. or other \_\_\_\_\_  
Address Hospital Harre de Grace Date signed 3.28.48

RECEIVED

APR 1 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02840

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County Harford  
City or town Laure de Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Harford  
City or town Laure de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 512 Levin St.  
(If rural, give LOCATION)

2. (a) If veteran, name War

## 3. (a) FULL NAME

Bobby Box Ingram, WILLIE JUNIOR

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

newborn infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Mar. 22-48 at 8:45 pm

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5 hrs. 15 min.9. Birthplace Laure de Grace Harford Md.  
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

12. Name Willie Miller  
13. Birthplace Sumter South Carolina  
14. Maiden name Rolla Road  
15. Birthplace Greenwood Miss.16. Informant Willie Miller  
Address 514 Freedom St. Harford Md.17. Burial Date thereof March 24 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. James CemeteryLocation Angle Hill18. Funeral director Calmer E. BullockAddress 556 Lewis St. Harford Md.19. Mar. 24 19 48 A. L. Lewis M. D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948 at 2 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 22-48 19 to Mar. 23 1948and that I last saw him alive on Mar. 22 1948Immediate cause of death Central respiratory failureDue to Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

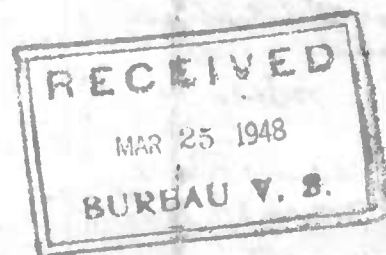
Means of injury Injured at work?

23. SIGNATURE John F. Noguera MDAddress Laure de Grace Md. Date signed 3/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of  
age and birth date  
Shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02841

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

FILM No. G 114 MAR 30 1948

1. PLACE OF DEATH:

County Hanford

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

House De Grace Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Hanford

City or town Rocks (Rural)  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Annie Jamison

3. (b) Social Security Number

4. Sex

F.

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

(widowed)

6. (b) Name of husband or wife

John Jamison

7. Birth date of deceased (mo., day, yr.)

1962 - - 1867

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

81 8 2

hrs. min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER  
MOTHER

12. Name

Nolan

13. Birthplace

not known

14. Maiden name

h. n.

15. Birthplace

16. Informant

Address

Miss Charles Walter  
Rock Hanford Co Md

17.

(Burial, cremation, or removal, which?)

Date thereof

Mar 18 1948

Cemetery or crematory

Location

18. Funeral director

Address

St James (colored)  
Federal Hill  
Charles E. Hunt  
Parrattsville Md

19.

(Date rec'd by registrar)

A. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16<sup>th</sup> 1948 at 7<sup>45</sup> A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 8. 48 19..... to Mar 16. 48 19.....

and that I last saw him alive on Mar 15. 48 19.....

Immediate cause of death

Cerebral vascular accident

DURATION

Due to

Hypertensive cardiovascular disease

Due to

Other conditions

Generalized arteriosclerosis  
+ chronic myocarditis

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera MD

M. D. or other

Address Hospital - H. de Grace Date signed 3.16.48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02842

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Harford  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 63

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2. (a) If veteran, name war. No

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife B. S. J. Jordan7. Birth date of deceased (mo., day, yr.) Nov. 27, 1882 6. (c) If alive, give age 62 years8. AGE: Years 65 Months 3 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford Co., Md.  
(Town, county, and state)10. Usual occupation Housework11. Industry or business At Home12. Name H. S. Pyle13. Birthplace Harford Co., Md.14. Maiden name Eugenia B. Monks15. Birthplace Harford Co., Md.16. Informant Mrs. B. S. J. JordanAddress Baltimore Md.17. Burial Baltimore Date thereof March 8, 1948

(Burial, cremation, or removal) (month) (day) (year)

Location Harford Co., Md.18. Funeral director H. S. BaileyAddress Baltimore Md.19. March 6, 1948 M. H. Kirk

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 5 1948 at 11:45A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1947 to MARCH 5 1948and that I last saw h. c. s. alive on MARCH 4 1948

Immediate cause of death

CARDIO-VASCULAR FAILUREDue to Arterio Sclerosis + Hypertension

Due to \_\_\_\_\_

Other conditions Cerebral Hemorrhage2 months  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Dudley Phillips, MD

M. D. or other \_\_\_\_\_

Address Baltimore Date signed 3/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02843

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County HanfordCity or town Beth Air  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Indiana CountyCity or town La Porte  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Arthur C Seadle

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced WB. (b) Name of husband or wife Amelia P. Seadle7. Birth date of deceased (mo., day, yr.) Dec 13-1882 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Walworth Wis  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Joseph C Seadle13. Birthplace Wis14. Maiden name Elizabeth Batchlet15. Birthplace Wis16. Informant Mrs Madelyn L WittAddress Beth Air17. Burial Date thereof Mar 23/48  
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Gene Lake CemeteryLocation La Porte Ind18. Funeral director Jos T. FosterAddress Beth Air19. 3/19 48 P. Fourwood  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 48, at 9:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 48, to March 18 19 48and that I last saw him alive on March 18 19 48Immediate cause of death Cerebral Thrombosis DURATION 3 hours

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Pernicious A anemia 1 year

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Lorrell C Palmer M.D. M. D. or otherAddress Beth Air, Ind Date signed 3/19/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 23 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02844

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County HarfordCity or town Harde Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harde Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 Ontario

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

William Eric Malin

## 3. (b) Social Security Number

—

## 4. Sex

male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mrs. Wm. Abbott Malin6. (c) If alive, give age 7 years

## 7. Birth date of

deceased (mo., day, yr.)

June 19, 1898

## 8. AGE:

Years

Months

Days

If less than one day

49823

hrs. min.

## 9. Birthplace

Bridgeport Conn.

(Town, county, and state)

## 10. Usual occupation

Maintenance; friendly oil

## 11. Industry or business

## FATHER

## 12. Name

Eric Malin

## 13. Birthplace

Sweeden

## MOTHER

## 14. Maiden name

Euna Olson

## 15. Birthplace

Sweeden

## 16. Informant

Mrs. Wm. G. Malin

## Address

605 Ontario, Harde Chase

## 17. Burial

Burial

## Date thereof

3/16/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Mt. Zion

## Location

Harde Chase

## 18. Funeral director

Peunington & Son

## Address

Harde Chase

## 19. Mar. 15

1948G. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 1948 at 2:12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1948 to Mar 13 1948and that I last saw him alive on Mar 13 1948

## Immediate cause of death

Chronic Myocarditis

## DURATION

## Due to

Chronic Stom. Nephritis

## Due to

Chronic Stom. Nephritis

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Charles J. Foley M.D.Address Harde Chase Date signed 3/15/48

RECEIVED

MAR 17 1948

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02845

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural Del Air  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 mo  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Rural Del Air  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Shirley Corner  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William H. Parrott

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband Bertha C. Snowden  
 7. Birth date of deceased (mo., day, yr.) April 22, 1885 6.(c) If alive, give age 54 years  
 8. AGE: Years 62 Months 11 Days  If less than one day  hrs.  min.

9. Birthplace Baltimore Co. Md  
 (Town, county, and state)  
 10. Usual occupation Day Laborer  
 11. Industry or business Private family  
 12. Name Ely Parrott  
 13. Birthplace Baltimore Co. Md  
 14. Maiden name Sarah Parrott  
 15. Birthplace Baltimore Co. Md  
 16. Informant Mrs. William H. Parrott  
 Address Del Air Md. P.F.D.  
 17. Burial Date thereof Mar 17 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Clarks Chapel  
 Location Near Darlington  
 18. Funeral director Henry Tanning Sons  
 Address Chesapeake Md  
 19. 3/15/48 19 48 00 10 00 00  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1948 at 4:00 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT 1, 1947 to Mar 14, 1948  
 and that I last saw him alive on Mar 9, 1948

Immediate cause of death Carcinoma of Stomach  
Chr Myocardial Disease  
 Due to Decompensated

DURATION

72 yrs

Due to   
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  Date of op.

Autopsy results   
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  Date of   
 Where did injury occur?  (City or town)  (County)  (State)  
 Injured at home, farm, industry, public place (where?)   
 Means of injury  Injured at work?

23. SIGNATURE Willard P. Hudson, M.D. M. D. or other   
 Address Forest Hill, Md Date signed 3/15/48

RECEIVED

MAR 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02846

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred.

214 Freedom St.  
How long in hospital or institution? 3 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 214 Freedom St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Calvin Parson Sr.

## 3. (b) Social Security Number

?

4. Sex

Male

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Ella Parson

7. Birth date of deceased (mo., day, yr.)

1970 unk6. (c) If alive, give age unk years

8. AGE:

Years

Months

Days

If less than one day

78

-

-

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Mr Calvin Parson JrAddress 214 Freedom St. Harre de Grace Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 15 1948  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

Mar. 15 19 48G. L. Lewis M. D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 13 19 48 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 9 19 48 to Mar. 13 19 48  
and that I last saw him alive on March 9 19 48

Immediate cause of death

Coronary Heart Failure

DURATION

Due to

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. J. Simon

M. D. or other

Address

Harre de Grace

Date signed

3-13-48

**RECEIVED**

MAR 16 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

02847

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

### 1. PLACE OF DEATH

County Harford  
City or town Aberdeen  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution Edmond Street Extension  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) 28 years

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Harford  
City or town Aberdeen Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. Edmond Street Extension  
(If rural give LOCATION)  
2(c) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Sarah Prigg

### 3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife George Warfield

7. Birth date of deceased (mo., day, yr.) March 22, 1870

8. AGE: Years 78 Months 0 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Perryman, Harford, Md.  
(Town, county, and state)

10. Usual occupation housewife.

11. Industry or business none

12. Name William Holland

13. Birthplace Harford County, Md.

14. Maiden name Maria Lewis

15. Birthplace Harford County, Md.

16. Informant Annie Scott

Address Aberdeen, Md.

17. Burial Date thereof March 27, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union M. E.

Location Near Aberdeen

18. Funeral director Henry Tarrington & Sons

Address Aberdeen, Md.

19. Mar 26 48 Nellie J. Riley  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 48, at 6<sup>55</sup> P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 19 48, to March 23 19 48  
and that I last saw her alive on March 21 19 48

Immediate cause of death hypostatic pneumonia DURATION 3 days

Due to Congestive Heart Failure 19 days

Due to Generalized + coronary arteriosclerosis unknown

Other conditions left hemiplegia following cerebral hemorrhage 19 days  
(Include pregnancy within 3 months of death)

Major findings: none PHYSICIAN \_\_\_\_\_

Of operations none Please underline the cause to which death should be charged statistically.

Of autopsy none

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Aubrey V. Gould Jr M.D.

23. SIGNATURE Have de Grace, Md. M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed 3/23/48

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 27 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. BENSON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02848

Reg. Dist. No.

185

## 1. PLACE OF DEATH:

County HARFORD  
 City or town HAURE DE GRACE  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 DAYS

Hospital, institution, or street address where death occurred:  
HARFORD MEMORIAL Hospital

How long in hospital or institution? 6 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HARFORD

City or town CONOWINGO RURAL  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ROUTE 222 1 MILE SOUTH RD #1  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sophie QUENZER

## 3. (b) Social Security Number

## 4. Sex

FEMALE

## 5. Color or race

WHITE

## 6.(a) Single, married, widowed, or divorced

WIDOWED

## 6.(b) Name of husband or wife

Deceased.

## 7. Birth date of deceased (mo., day, yr.)

7-16-1865

## 6.(c) If alive, give age

1865 years

## 8. AGE:

82525hrs.min.

## 9. Birthplace

GERMANY  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

None

FATHER  
MOTHER

## 12. Name

HENRI WETZEL

## 13. Birthplace

GERMANY

## 14. Maiden name

HELENA WOLF

## 15. Birthplace

Germany

## 16. Informant

Elizabeth Day

## Address

145 Old Stewart St. Lancaster Pa

## 17.

Burial

## Date thereof

3-13-1948

(Burial, cremation, or removal. Where?)

## Cemetery or crematory

Zion Lutheran Cem. Lancaster Co.

## Location

Lancaster Penna

## 18. Funeral director

Fred J. Graff Inc

## Address

234 W. Orange St. Lancaster Pa

## 19.

Mar. 11 19 48G. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 11, 1948 at 3:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 5-48 to Mar. 11 1948and that I last saw him alive on same 19 19

Immediate cause of death Primary anemia  
leukemia

## DURATION

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm F Noguera M.D.Address Hospital - H de Grace Date signed 3/11/48

**RECEIVED**

MAR 12 1948

**BUREAU V. 8.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a

02849

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County.....*Harford*  
 City or town.....*Rocks*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland*..... County.....*Harford*

City or town.....*Rocks*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Robert Francis Rutherford

## 3. (b) Social Security Number

4. Sex.....5. Color or race.....6.(a) Single, married, widowed, or divorced.....

*M.**W.**S.*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*Mar 22, 1948*  
 6.(c) If alive, give age.....years

8. AGE: Years.....Months.....Days.....If less than one day.....*2*.....hrs.....min.

9. Birthplace.....*Rocks, Harford Co. Md.*  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....*George Clay Rutherford*  
 13. Birthplace.....*N.C.*

MOTHER 14. Maiden name.....*Hannah Jones*  
 15. Birthplace.....*Harford Co. Md.*

16. Informant.....*George C. Rutherford*  
 Address.....*Rocks, Md.*

17. Burial.....Date thereof.....*Mar 23, 1948*  
 (Burial, cremation, or removal. Which?).....(month) (day) (year)

Cemetery or crematory.....*Centre*  
 Location.....*Forest Hill Md.*

18. Funeral director.....*Martine G. Hurst*  
 Address.....*Garrettsville, Md.*

19. *Mar 23*.....19*48* *Thomas P. Brown*  
 (Date rec'd by registrar).....Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 22*.....19*48*.....at *7:45 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*March 22*.....19*48*.....to.....*March 22*.....19*48*  
 and that I last saw h.....im.....alive on.....*March 22*.....19*48*

Immediate cause of death.....*Cerebral hemorrhage*  
 DURATION.....*2 hrs.?*

Due to.....*Trauma incident to birth.*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

23. SIGNATURE.....*Willard P. Hudson M.D.*  
 M. D. or other.....

Address.....*Forest Hill, Maryland*.....Date signed.....*3/23/48*

RECEIVED

MAR 26 1948

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH  
shown on:

2411 N. Charles St., Baltimore

FILM No. G 115 APR 14 1948 CERTIFICATE OF DEATH

02850

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford  
City or town Fallston  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Harford  
City or town Fallston  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Charles R. Spencer

3. (b) Social Security Number

4. Sex <u>M</u>	5. Color or race <u>Negro</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
--------------------	----------------------------------	--

6.(b) Name of husband or wife  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) Dec. 20, 1983  
8. AGE: Years 55 Months 64 Days If less than one day  
hrs. min.

9. Birthplace Maryland  
(Town, county, and state)  
Laborer

10. Usual occupation

11. Industry or business

12. Name George Spencer

13. Birthplace Md.

14. Maiden name Mary Ruff

15. Birthplace Md.

16. Informant Daniel Spencer

Address Fallston, Md.

17. Burial Date thereof 4/3/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Tabernacle A. M. E.  
Benson, Maryland.

Location

18. Funeral director Thos E. Gray

Address Benson, Md.

19. 3/31 48  
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 30 1948 to March 30 1948  
and that I last saw him alive on March 30 1948

Immediate cause of death Cerebral thrombosis. DURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other

Address Forest Hill, Maryland. Date signed 3/31/48

RECEIVED  
APR 3 1948  
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02851

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County Harford  
 City or town HARFORD de GRACE  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cecil  
 City or town Colona  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Mrs. Alice Stewart

## 3.(b) Social Security Number

4. Sex

F.

5. Color or race

W.6.(a) Single, ☒ married, widowed, or divorced

6.(b) Name of husband or wife

Clarence Stewart

7. Birth date of

deceased (mo., day, yr.)

January 6, 18736.(c) If alive, give age 15 years

8. AGE:

Years

Months

Days

If less than one day

75213

hrs.

min.

9. Birthplace

Morristown, N. Jersey

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 18<sup>th</sup> 1948 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

March 15, 1948 to March 18, 1948

and that I last saw him alive on

March 18, 1948

Immediate cause of death

DURATION

Lobar pneumonia  
& pleurisy

Due to

Due to

Other conditions

Chronic myocarditis  
and arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

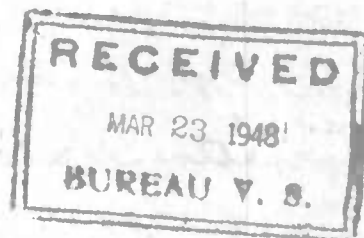
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera MD  
Hospital - Hane de Grace Date signed 3-18-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

02852

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County Harford  
 City or town Harre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
300 Bourbon St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford  
 City or town Harre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 300 Bourbon St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

John Franklin Sutor

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Myrtle Edith Sutor

## 7. Birth date of deceased (mo., day, yr.)

Feb. 12, 1873

## 8. (c) If alive, give age, years

64

## 8. AGE:

Years

Months

Days

It less than one day

75117— hrs.— min.

## 9. Birthplace

Harre de Grace, Md.  
(Town, county, and state)

## 10. Usual occupation

Painter

## 11. Industry or business

## MOTHER

## 12. Name

John Sutor

## 13. Birthplace

Md.

## 14. Maiden name

Rebecca Seal

## 15. Birthplace

Perry

## 16. Informant

Mrs. M. Edith Sutor

## Address

300 Bourbon St. - City

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

Apr. 11, 1948  
(month) (day) (year)

## Cemetery or crematory

Angel Hill

## Location

Harre de Grace

## 18. Funeral director

J. Madison Mitchell

## Address

Harre de Grace, Md.

## 19. Date rec'd by registrar

Mar. 31, 1948G. L. Lewis m. d.

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 29, 1948, at 9<sup>15</sup> A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 10 48 to Mar 29 48  
and that I last saw him alive on Mar 29 48

## Immediate cause of death

Arteriosclerosis  
Cerebral Hemorrhage

## DURATION

## Due to

## Due to

Cardiac Failure

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Charles J. Foley M.D.

M.D. or other

Address

Harre de Grace, Md. Date 3/31/48

RECEIVED

APR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

02853

## CERTIFICATE OF DEATH

Reg. Dist. No.

170

## 1. PLACE OF DEATH:

County HARFORDCity or town EDGEWOOD  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County HARFORDCity or town EDGEWOOD  
(If outside city or town limits, write RURAL and give nearest town)Street No. 31 ARMSTRONG  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

JAMES EMANUEL WATERS, JR.

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced SINGLE6. (b) Name of husband or wife NONE7. Birth date of deceased (mo., day, yr.) JULY 27, 19448. AGE: Years 3 Months 7 Days 24 It less than one day - hrs. - min.9. Birthplace HARFORD Co.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name JAMES E. WATERS13. Birthplace BERLINGTON, N.J.14. Maiden name HAZEL LEE15. Birthplace WHITEFORD, MD.16. Informant JAMES WATERSAddress EDGEWOOD, MD.17. BURIAL Date thereof 3/23/49  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory SLATE RIDGELocation YORK Co., PA.18. Funeral director Hubert P. HarkinsAddress Delta, Pa.19. 3/21 19 48 Mamie M. Moulds  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 19 48 at 10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/1 19 47 to 3/21 19 48and that I last saw h. 1M alive on 1/10/48 19 -Immediate cause of death INFANTILE PARAPLEGIA & MENTAL RETARDATIONDURATION 1 1/2 YEARS

Due to

Due to

Other conditions MALNUTRITION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles W. Stewart Jr. M.D.  
M. D. or otherAddress 12 YAHDE ST. EDGEWOOD, MD. Date signed 3/21/49

RECEIVED

MAR 23 1948

BUREAU V. S.